
# medical review and advisory board

OF THE CALIFORNIA MEDICAL ASSOCIATION

## What Price Medical Malpractice Insurance?

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THE PROBLEMS associated with medical malpractice insurance are obvious to any physician, what with the rapid and progressive increase in premiums for such insurance during the past ten years. Articles on the subject have appeared in medical journals and other types of publications; some of these articles are sound, others reveal that the individual writing the article has little or no comprehension of the basic factors involved in this field.

The purpose of the present article is to discuss in general fashion the various factors playing a role in insurance coverage of this type. This article is written from physician to physician; therefore the details will be presented along the lines of interest to physicians rather than from the viewpoint of attorneys or insurance experts.

It is, first, important to realize that this problem is not confined to California. Indeed, the problem is nationwide, with particular emphasis recently in the states of New York, Illinois, Florida, Connecticut, Maryland and the District of Columbia. In some of these states the insurance carrier covering a group program has cancelled its group coverage because of increasing hazard in which the ratio of losses to premiums (loss ratio) continued to increase despite the rapid increase in premiums.

As an example of the increasing hazard in California, statistics show that for a group Northern California malpractice program during the period 1946 through 1951, one of every twelve physicians had a malpractice claim of some type levied against him each year. Breaking this figure down further, it is noted that one of every fifty-two physicians in the program had an actual malpractice suit filed against him each year, while one of every fourteen physicians had a serious allegation presented by a patient that required investigation by the insurance carrier. As a result, premiums in this group program have risen almost 200 per cent during the eight-year period from 1946 to 1954.

The growing dissatisfaction of insurance carriers with the field of medical malpractice insurance is disturbing. More and more carriers are dropping out of this type of insurance. Some carriers, realizing that this has been a losing field, are only offering the insurance to a physician if he permits the carrier to sell him other insurance such as automobile insurance, home insurance, personal liability insurance and so forth. This is commonly known as the "package deal."

### DISSATISFACTION OF INSURANCE CARRIERS

Factors that make the insurance carrier dissatisfied may generally be classified as follows: (1) The problem of latent liability; (2) The progressive in-

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crease in losses in such insurance due to inflation and the increasingly critical attitude of the public, the juries and the courts; (3) The small volume of sales of this type of insurance; and (4) The growing dissatisfaction of physicians with the progressive increase of premiums by means of which the insurance carrier hopes to balance the program.

The latent liability factor is entailed in the long lapse of time between the alleged act of malpractice and to filing of a claim or suit. With automobile liability insurance, the carrier knows at the end of the given policy year or shortly thereafter the entire extent of its liability. With medical malpractice, however, claims for alleged malpractice may come up many years after the incident that is cited as a basis for claim. This is due to the very unfavorable statute of limitations in California which basically provides that a patient may file a suit or claim against a physician one year after the patient has acquired knowledge of an act of malpractice. Basically, this means that the patient has practically his entire lifetime or the physician's lifetime in which to file suit. For instance, if a surgeon inadvertently leaves a clamp in an abdomen during an operation and the patient is told forty years later when a gastrointestinal series is made that such a clamp is present, the patient has one year thereafter to file a suit. Consequently, it is extraordinarily difficult for insurance carriers to predict losses with any accuracy for a given policy year, since the policy for the year in which the incident occurs is the policy which covers the physician for the rest of his life, regardless of the year in which the suit is filed.

That both the incidence of malpractice claims and size of judgments and settlement costs are increasing is clear not only in California but in other states. For instance, actuarial data in one state reveal that the incidence of malpractice suits per unit number of physicians has increased 100 per cent during the past ten years. Inflation has likewise produced an increase in judgments and an increase in the cost of defense during the same period.

In contrast with other types of insurance, sales in malpractice insurance are relatively small and consequently an insurance carrier would make relatively little profit, even if this type of insurance were profitable. As a result, the average insurance carrier looks upon the selling of malpractice insurance as a "courtesy" or "accommodation" line, rather than as a profitable enterprise.

Another facet of the problem is the growing dissatisfaction of physicians with increasing premium rates. This dissatisfaction is due to the failure of the physician not only to realize the problems involved, but also the fact that such insurance has recently been a losing proposition to the carrier. The Medical Review and Advisory Board has had the opportunity of reviewing financial data for a number of insurance carriers selling malpractice insurance in California. In no instance was the board able to find evidence of even a reasonable profit; indeed, the carriers making information available to the board presented statistics which showed that the insurance coverage was carried at a financial loss during the period studied.

### CALCULATION OF PREMIUMS

Medical malpractice insurance premiums, like premiums for other types of insurance, are calculated on the basis of expected losses plus expected expenses. In the best of circumstances where accurate data are available on the history of losses, the insurance carrier takes this financial data into account and adds to it the cost of administering the policy (sales, federal and state taxes, home and district office expenses, and employees' salaries), costs of special investigation, court costs, attorneys' fees, and agents or brokers' commissions (if the company is a stock company) to arrive at a given annual premium. In the case of a stock company, a fair dividend return to the stockholders is included in the expenses. In the case of a mutual company, any profit resulting from a given year's sale of the insurance returns to the buyer either in the form of a dividend or as reduced premiums in future years. In the case of medical malpractice insurance, the calculation of premiums is extraordinarily difficult due to the factors of latent liability, inflation, an increasingly critical attitude of the public, and the generosity of juries in awarding higher and higher judgments. Therefore, medical malpractice premiums are set by an educated guess at the very best in this day of rapidly increasing problems.

### "RESERVES"

Many physicians have asked about the question of "reserves." There are generally two types of reserves in any insurance company. First come the general reserves of the company which are generally set aside for catastrophic events and generally depend upon the size of the insurance carrier. Second, are the reserves that are set aside in safe-keeping when a case with possible loss is reported, so that there is a guarantee to the holder of the insurance policy that there will be sufficient money to pay the claim, or judgment in a suit, if and when such payment becomes due. This type of reserve is set up by the company and represents, in the best judgment of the insurance carrier, the amount that the claim or suit will cost, taking into consideration the award to the plaintiff, court costs, attorneys' costs in defending, and costs of special investigation.

Such reserves may vary in amount from less than $100 to even the entire limit of coverage of the

physician, depending upon the seriousness and liability of the case. If there is no liability, the reserves will be very minimal, reflecting only the costs of special investigation.

In general, insurance carriers are very skillful in setting up such reserves and in most instances successful claims over a period of one or several years when averaged out for many cases come to within 10 or 15 per cent of the amount originally set aside. When money is set aside in such specific reserves, the money is not necessarily lost to the program. In other words, if the case is successfully consummated in so far as the defendant physician is concerned, the money is taken out of the reserve and is put back into the program, thereby eventually lowering premiums or becoming payable in the form of dividends.

#### MUTUAL vs. STOCK COMPANIES

There has been much discussion concerning pros and cons of the so-called mutual company versus the stock company. In general, a stock insurance carrier is owned by shareholders, such as any ordinary corporation. These shareholders receive a dividend return on their shares of stock, ranging from two to five per cent, generally. With a mutual company, there are no stockholders; indeed, the policyholders themselves own the company by virtue of their policies. There are no stockholders to pay, and any profits resulting at the end of the year are added to general surplus or returned to the policy holder by the payment of dividends or reduction of premiums during the next year. Also, in general, policies for stock companies are sold through agents or brokers, while policies for certain mutual companies are transacted by salaried company employees.

It is profitless to discuss the pros and cons of the stock versus mutual company, since the matter is one of individual preference. Further, the efficiency, skill, and service of companies is a variable factor. The important point is that the policyholder have his insurance in a reputable, long-established company which will give every assurance of being in the business throughout the lifetime of the physician and that has assets in the United States available for defense and paying claims. Whether the company be stock or mutual is of little concern, and premiums are of secondary consideration.

The important criteria for a physician to consider in selecting a carrier are:

1. Past and future stability of carrier.
2. Adequate reserves of the carrier on deposit in the United States.
3. Group program sponsored and monitored by a county or state medical society.
4. Offering by the carrier of sufficiently high coverage to adequately meet a high judgment.
5. Limitation of "cancellation" clause.
6. Limitation of "exclusion" clauses.
7. Contingent liability coverage (for the acts of a physician's partner).
8. Permanence for yearly renewal of the policy.
9. Absence of hidden additional charges.
10. Sufficient volume of business in the area in which the physician practices to have experienced malpractice claims adjustors and defense counsel.

#### GROUP PROGRAM vs. INDIVIDUAL POLICIES

There is little or no doubt that a group malpractice program has many advantages over the individual malpractice policy. Here the physician has the basic advantage of group protection and group negotiation with the carrier along the following lines:

1. Prevention of discrimination against physicians whom the carrier considers hazardous risks because of their field of work. (This danger already exists. For instance, there is one insurance carrier which rejects orthopedists, plastic surgeons, and radiologists from coverage.) Who is to be excluded from medical malpractice coverage should be a determination of physicians rather than insurance people.
2. Prevention of the possible control by the insurance company over what procedures the doctor may perform. Such control, preventing the performance of hazardous procedures, may easily be accomplished by the carrier through exclusions in the individual policy or by the device of surcharges so high the physician cannot afford to pay the premium.
3. The medical profession itself may have considerable influence over which claims are to be settled and which are to be defended in a group program. Thus the decision is influenced by analysis of the merit of the claim rather than by expediency.
4. The training of competent claims managers and the team approach to claim handling and defense is accomplished in a group program. Such effective programs are found in groups rather than in individually handled policies.
5. An effective prevention—or safety—program may be set up with a long-term view of reducing the incidence of claims or lessening liability.
6. The collection of loss data by physicians in a group program may be accomplished with the objective of testing the reasonableness of premiums and, most important, of establishing the underlying or real causes of claims.
7. The long-range interests of the profession are served in a group program rather than the immediate

interests of the insurance carrier by physicians influencing and guiding the course of malpractice insurance. The insuror can desert the field of malpractice, but the profession has to live with it. The problem is basically medical in nature rather than insurance.

#### LOCAL GROUP PROGRAMS vs. NATIONAL GROUP PROGRAMS

What has been said above on the subject of group programs in malpractice insurance does not necessarily apply to national specialty group programs. Several such national programs have been started in the recent past, and one such specialty group already has been suddenly dropped by the insurance carrier involved.

While a group national specialty program may have a cost advantage over individual insurance, this has not yet been demonstrated. On the other hand, national programs are not as advantageous to the physician as a local group program. The principal disadvantage of a national program is that it may lack concentration in an area, and therefore have so few claims that it does not have claims adjustors and attorneys sufficiently well qualified in the field. The handling of medical malpractice problems by the underwriters of national programs may be a very minor part of their total general work.

Another difficulty with the national program is the remoteness of the central claims office from the field of action. Consequently, there may be a tendency on the part of the carrier to settle on the basis of expediency, medical-professional appraisal of the case with coordination of the claims adjustor may be poor, and there may be little or no contact of the physician with the carrier.

Still another problem with national groups is the difficulty in setting up prevention or safety programs because of local state differences, court procedures and legal codes. Malpractice is not within the province of federal courts, but rather is governed by local and state courts—with differences not only among states but also among counties.

#### AMOUNT OF COVERAGE

With respect to the amount of insurance coverage for medical malpractice, several articles have lately appeared in journals circulated to physicians, recommending low coverage. The argument is that low coverage will discourage claims and will tend to lower the amount of plea for damages or settlement. The author has never known or heard of a single malpractice case in which the plea for damages or settlement was influenced by the amount of insurance coverage. On the contrary, physicians leave themselves open to financial ruin with low coverage.

The problems connected with inadequate coverage have been increasingly great during the past several years. Recently in California two judgments in excess of $200,000 each were rendered. The author has been closely associated with the field of malpractice during the past five years and has seen the near tragedies which result with low coverage. The physician who carries coverage of $5,000/15,000 or $10,000/30,000 is indeed an unhappy person when he is faced with a suit in which the plea may be up towards $200,000, and if damages are awarded, the judgment may well run in the neighborhood of $50,000 to $75,000. The author has seen physicians become almost psychotic persons with the worry and fear of the approaching trial in cases of that kind.

What is considered adequate coverage? The answer is difficult, but of course basically it depends upon the individual's assets, both present and in prospect, to be protected, and also upon his type of practice. In general, a coverage of less than $50,000/100,000 should be considered inadequate in these days, and generally it is well to have coverage of $100,000/300,000. For physicians engaged in particularly hazardous work, such as anesthesiologists, vascular surgeons and neurosurgeons who perform work of a type that, regardless of skill and care, may lead to paraplegia as a complication, coverages up to $300,000/900,000 may be considered desirable. This is based specifically upon the fact that in California within the past few months, verdicts of $225,000 and $250,000 respectively have been awarded by juries for paraplegia following spinal anesthesia in one case and aortogram in another. The day of the $5,000/15,000 and $10,000/30,000 coverage has passed.

#### THE FUTURE

The future for the physician in medical malpractice insurance is dismal indeed. Each year brings forth new medical discoveries of importance with benefit to the patient; but as medicine progresses so likewise difficulties increase in practice with the use of complicated surgical procedures and the administration of toxic drugs. These lead necessarily to an irreducible number of complications for which the physician may be held responsible, and likewise lead to a greater burden placed upon the physician by the courts and by an increasingly critical public. The great advances in medicine and surgery, as presented to the layman in magazines, have led the public to be supercritical in appraising results. Our grandfathers didn't expect the horse-and-buggy doctor to be perfect, but our contemporaries expect perfection of today's physicians.

To seek aid from the public, the attorney, the legislature, and the courts is not necessarily the

answer at this time. The physician must begin the battle himself. As Ford[1] pointed out five years ago, in probably the shortest paper ever published on the subject but nevertheless most revealing, the control of medical malpractice hazards depends upon:

*Good faith*
*Good records*
*Common sense*

*Good faith* implies that the physician treat his patient with tact and kindness, that he conceal no known difficulty in diagnosis or treatment, and that he advise consultation freely.

*Good records* means that the physician adequately document his medical records of a patient, carefully record untoward happenings, and make a matter of record the treatment given and advice offered.

*Common sense* implies that the physician know the vindictiveness of some patients, recognize the hazard connected with the collection of reluctant fees, be aware of the failure of equipment which in turn can produce injury, and finally, use only well established medications and procedures.

**REFERENCE**

1. Ford, R.: Medical malpractice, New Eng. J. Med., 243:408, Sept. 14, 1950.

## CANCER DIAGNOSTIC TESTS: *PENN REACTION*

A Statement by the Cancer Commission of the California Medical Association (May 1954; reaffirmed, October 1955.)

FROM TIME TO TIME, announcements appear in the press concerning new alleged cancer tests. Up to the time of preparation of this statement, not one of the numerous "blood tests" for cancer has withstood scientific investigation. Many have given rise to false positive results with distressing consequences to patients and their families.

During the last few months, there has been considerable publicity concerning a so-called seroflocculation reaction for cancer, otherwise known as a Penn or Penn-Dowdy blood test. As far as the Cancer Commission of the California Medical Association can ascertain, the following is the present status of this procedure.

1. The Penn seroflocculation reaction is not a cancer test. It is positive in a majority of patients with cancer *and* in patients who:

(a) recently have had injury or operation;
(b) have active rheumatoid arthritis;
(c) have cirrhosis of the liver;
(d) have fever over 100 degrees;
(e) have active tuberculosis;
(f) are pregnant;
(g) are taking medication such as desiccated thyroid, estrogens, insulin, epinephrine and corticotropin (ACTH).

In other words, this experimental test is positive in many conditions besides cancer, and is therefore nonspecific.

2. In a certain number of patients who actually have cancer, the reaction is negative. The precise number of such false negative reactions and of the previously mentioned false positive reactions is under investigation at present. It will take many months, if not years, to complete this investigation. The minute that reliable information concerning the value of this reaction in independent hands is available, it will be made public.

3. Should this reaction prove to be of such value as to endorse its general use, it would constitute a supplementary item of evidence in the differential diagnosis of cancer. Its responsible proponents do not suggest, as yet, that it deserves any consideration in mass screening of asymptomatic individuals.

4. The National Research Council maintains a Committee on Cancer Diagnosis and Therapy. This committee has prepared criteria for the evaluation of diagnostic procedures. The Cancer Commission of the California Medical Association has recommended that investigators note these carefully prepared criteria and that due attention be given to them in making clinical tests on any type of proposed cancer diagnostic procedures.

5. Pending the discovery of a particular blood or chemical test, citizens are urged to utilize tried and tested methods of cancer detection. The most reliable method consists in physical examination by a qualified physician.